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Genealogies of recovery: The framing of therapeutic ambitions

Abstract

The notion of recovery has become prominent in mental health care discourse in the UK, but it is often considered as if it were a relatively novel notion, and as if it represented an alternative to conventional treatment and intervention. In this paper we explore some of the origins of the notion of recovery in the early 20th century in movements such as Alcoholics Anonymous and Recovery Inc. Whilst these phenomena are not entirely continuous with recovery in the present day, some important antecedents of the contemporary notion can be detected. These include the focus on the sufferers' interior space as a key theatre of operations and the reinforcement and consolidation of medical ways of seeing the condition without any immediate medical supervision of the actors being necessary. This has resonance with many contemporary examples of recovery in practice where the art of living with a mental health condition is emphasised without the nature of the psychopathological condition itself being challenged.

Keywords

Recovery; mental health; alcoholism; genealogy

Genealogies of recovery: The framing of therapeutic ambitions

Introduction: The present and past of recovery

In this paper we will critically unpack the notion of recovery in mental health care in relation to several historical strands which have combined to help shape the concept and its related practices as we know it today. A striking feature of many mental health care policies and services in the present is how readily the idea of recovery has moved from being a marginal to a central concern in mental health services in the UK (Harper and Speed, 2012; Pilgrim, 2008), North America (Anthony, 1991, 1993), Australia and New Zealand (Australian Health Ministers, 2003; O'Hagan, 2001; Ramon, Healy, & Renouf, 2007) and elsewhere in a relatively short amount of time. It has emerged in the discourse of clients and practitioners and also as a structuring principle in service organisation and philosophy.

The expansion of recovery as a principle of service delivery and a therapeutic goal has arisen in response to, and in parallel with, a related discourse concerning the continuing and growing burden of mental disorder, often said to be the second greatest financial and social burden after cardiovascular disease (Wittchen 2011; CMH 2010; ECNP 2009; WHO 2005). It is in this context that recovery presented as a new paradigm for mental health care with potential to alleviate the pressure on existing statutory and charitable provision and to offer a more client-centred and even emancipatory approach to mental health care. Hence the idea of 'recovery' is placed in the foreground, for example in the UK, where the Department of Health's implementation framework for mental health (DoH,

2011b) exhorts health and care services to 'focus on recovery, rehabilitation and personalisation' (p. 5) and that to achieve this 'frontline workers, across the full range of services, are trained to understand mental health and the principles of recovery' (p. 12).

In the UK, this renewed policy activity takes place against a backdrop of ongoing discussions about 'crisis' in mental health care. From themed workshops about the nature of the crisis at the 2012 Social Work Action Network conference (Spandler and Poirsanidou, 2012) to reports on the operation of mental health legislation by the House of Commons (Health Committee, 2013) crises are identified in issues such as the shortage of beds, the sparse coverage of services, the growing securitisation and use of compulsion in residential care and limitations in services for specific groups like young people and ethnic minorities. Certainly, this atmosphere of crisis in mental health care has provided fertile ground for innovation, and the recovery movement has grown rapidly and vocally to fill the gap as part of a growing interest in self-help and a reaction to the perceived weaknesses of public mental healthcare (Beresford et al 2010; Davidson et al 2010; Repper and Perkins 2003).

Hence, recovery has become central to recent policy in the UK (DH 2011), and is supported by professional, third sector and activist movements (Shepherd, Boardman & Slade, 2008; Boardman & Shepherd, 2009). There is a recognition of the need to redesign services to encourage resilience (Amering and Schmolke 2009), and to address the difficulties expressed by service users themselves who stress that social context, such as housing, work, friendships and public attitudes are the key source of their difficulties. There is enormous energy behind this new 'recovery' approach.

It is therefore important to examine how the idea of recovery as a way of thinking about and practicing mental health has come about and how it has taken on its present shape and form. The notion of recovery has a specific history in relation to mental health care, and the critical understanding of the trajectory of this notion is important if we are to make sense of its current formulation and the ease with which it has travelled and translated itself within the institutional structures of contemporary healthcare organisations and has rendered itself legible to policymakers and public service managers.

To do this we will explore the origins and evolution of the concept via a genealogical method with its origins in Michel Foucault's writing. As is well known, Foucault uses the concept of genealogy as a methodological notion or title for his critical historical-philosophical projects, but also elsewhere he uses it more broadly to denote the 'history' or 'genesis' of an idea or practice. It is difficult to pin down exactly, because in the works which he claimed were genealogical, such as *Discipline and Punish* and *The History of Sexuality* and some texts of his 'middle' period (c. 1970–1976/77), a variety of connotations are attached to the approach. 'First, a historical ontology of ourselves in relation to truth through which we constitute ourselves as subjects of knowledge; second, a historical ontology of ourselves in relation to a field of power through which we constitute ourselves as subjects acting on others; third, a historical ontology in relation to ethics through which we constitute ourselves as moral agents.' (Rabinow, 1991, 351).

There is now a lively tradition of literature which addresses the development of how we have come to see ourselves as human beings. As one of its foremost practitioners, Nikolas

Rose (2000), reminds us, this genealogy of subjectification approach owes a good deal to Foucault's focus on the 'problematizations through which being offers itself to be, necessarily, thought – and the practices on the basis of which these problematizations are formed' (Foucault 1990, 11). Thus, a genealogy of subjectification would explore the 'ways in which individuals experience, understand, judge and conduct themselves' (Rose 2000, 317) according to an 'authority of some system of truth and of some authoritative individual' (317).

Consequently, here we will consider how the concept and practice of recovery has been deployed, how it relates to broader structures of power and authority and what it means for how agents – practitioners, sufferers, carers and other 'stakeholders' - come to be constituted in their roles and what it means for how they come to think about how to lead a 'better' life.

There is, as several authors have observed, a tension in Foucault's work between the detailed – almost claustrophobic - description of the past and the tendency to draw analogies with the present. The concrete, highly local description of specific cases of 'powerful' subject construction contrast with the development of broad historical lines and developments (Saar, 2002, 238). For example, the notion of the Panopticon is interesting not because it influenced subsequent prison design (it did not) but because of how this idea generalises to be part of a new socio-political anatomy across many nations. The principles of observation and individuation, visibility and discipline, power and knowledge contained in Bentham's design provide a grid of intelligibility for understanding how power operates in contemporary societies (Garland, 2014, 376).

The genealogical method often begins with a kind of problematization or framing of the topic in the present day, in terms of how it is constructed and experienced. Accordingly, let us first consider how the idea of recovery has been framed in the contemporary period. The most widely used definition of recovery is one derived from the work of William Anthony (1993), which is worth quoting in full. Recovery is

...a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. (Anthony, 1993: 15)

The sheer ubiquity of this definition is noteworthy on several counts. First, it is a just over 20 years old, subtly effacing the long history of recovery concepts and practices prior to this point. It underscores the idea of recovery as a relatively new idea – one without history and not freighted with the coercive and oppressive histories which attach to psychiatry itself. It has, by these lights, emerged more or less fully formed in the modern, emancipated era. Also, in common with many definitions and implementations of recovery concepts, it is directed to the interior world – satisfaction, hope and meaning figure prominently. It is thus aligned with the late 20th century's preoccupation with seeing the citizen in psychological terms and the assiduous popular cultivation of the self which has been a major part of the social history of the last hundred years (Thompson, 2006).

Yet there are many reasons to treat the notion of recovery sceptically (Harper and Speed, 2011). From Foucault's generative work comes the insight that 'truth' in the field of therapeutic endeavour is perhaps best thought of as emerging from the 'effects of power' (Foucault, 1980: 132). Here it is crucial to ask who is the 'transmitting authority' making or disseminating policies and practices of recovery, and who are the subjects of the activity?

From a Foucauldian perspective we would suggest that recovery in mental health is likely to have 'several pasts, several forms of connexion, several hierarchies of importance, several networks of determination, several teleologies' and that such 'discourse must not be referred to the distant presence of an origin, but treated as and when it occurs' (Foucault, 2002a, p. 5, 28), so that differences and discontinuities allow new ways of operating vis-a-vis new 'regimes of truth' (Foucault, 1980). In this paper therefore we will consider the formulation, practice and discursive terrain on which mental health recovery has emerged in policy and practice, while also recognising that the politics of health and social are closely bound up with the political formation of other forms of expertise, professional and academic activity, including the role of the media in related fields including health and social policy and practice.

The genealogy of recovery in mental health

Some clues as to the present provenance of 'recovery' then can be ascertained by looking at its precedents. Let us trace some of the ideas and practices that inform our present-day activities and characterise the historical conditions upon which they still depend. The purpose is not to think historically about the past but instead to employ historical

materials to rethink the present, to explore how the normalizing powers of this apparatus impose upon us the demand that we position ourselves and our symptoms in discourse, that we confess, and that we regard our interior life as somehow constitutive of our individual selves.

Tracing the emergence of the concept of recovery in mental health, a significant precedent can be found in the work of Abraham Low (1891-1954) who, after medical study in Vienna, migrated to the United States in 1920. He held posts at the University of Illinois, eventually becoming director of its neuropsychiatric institute in 1940. Also, from 1931 to 1941 he supervised the Illinois State Hospitals. During this time he conducted seminars with the staff and interviewed the most severely disturbed mental patients in the wards. A prolific author, his publications covered a wide range of topics including infant speech development, the histopathology of brain and spinal cord, the clinical assessment of neurological and psychiatric problems, studies of speech disturbances in brain lesions, studies of the recently implemented programmes of shock treatment, laboratory investigations of mental illnesses and group psychotherapy. As well as his academic and medical interests, Low was concerned about the fate of former patients who had returned to life outside the hospital

In *Mental Health Through Will training* Low was concerned to assert that many symptoms, both mental and physical could be brought under control through exercise of will and judicious use of language: 'adult life is not driven by instincts but guided by will' (Low 1950: 12). The urgency of the task facing the physician in mental health care was all the more pressing because psychoanalysis was bankrupt 'on the evidenced of its own testimony', with limited effectiveness, exorbitant cost and limited application, with only

660 cases of treatment of over six months duration reported in the literature up to the early 1940s (p. 13).

Accordingly, in 1937, Low founded Recovery, Inc. He served as its medical director from 1937 to 1954. During this time he presented lectures to relatives of former patients on his work with these patients and made extensive use of before and after scenarios. In 1941, Recovery Inc. became an independent organization. Low's three volumes of *The Technique of Self-help in Psychiatric Aftercare* (including "Lectures to Relatives of Former Patients") were published by Recovery, Inc. in 1943.

The original thirty founding members had been discharged from hospital and were in the process of recovering their mental health after receiving insulin shock treatments at the Psychiatric Institute of the University of Illinois Medical School. Its purpose, as Low put it was 'to help prevent recurrences in mental diseases and to forestall chronicity in psychoneurotic conditions. Its techniques place the emphasis on self-help' (Low, 1950, p. 16).

Yet despite the emphasis on self-help, and Low's pride that the officers of the organisation such as the Chair, Vice President and Treasurer were ex-patients in recovery, the approach was led and directed by the doctor, namely Low himself. In his 1945 paper, Low is clear that the approach advocated is one in which the physician must be paramount. 'The authority of the physician is sabotaged if the patient presumes to make a diagnostic, therapeutic or prognostic statement' (Low, 1945: 98). Describing one's symptoms as 'uncontrollable', or 'unbearable' for example was seen as sabotage 'because of the

assumption that the condition is of a serious nature (diagnosis) and difficult to repair (prognosis)' (ibid. 98). Similarly, Low detected an impulse towards self-diagnosis in his patients which had also to be suppressed: 'Once the physician has made the diagnosis of a psychoneurosis or postpsychotic condition the patient is no longer permitted to indulge in the pastime of self-diagnosing. If he does he is classed as saboteur.' (Ibid. 98). Despite the appearance of severity, apparently 'it is comforting to the patient to be branded a saboteur' (99), and this comment is accompanied by statements directed at the presumed saboteur from veteran group members such as "Wait till you get well;" "wait till you will learn to give up sabotaging" (Low, 1945: 99) so as to suggest that this is not a permanent state of invalidism but that enlightenment is just around the corner. This emphasis on discipline and leadership was crucial to the efficient administration of therapy.

'Due to the fact that the patients are disciplined there is little quibbling and arguing in the physician's office which means that the so-called "resistance" to his explanations and directions is reduced to a minimum' (Low 1950: 35). Low was therefore able to boast that he could offer effective psychotherapy to as many as four or five patients an hour in his office. Indeed, psychotherapy, in his view should be more like a business.

As well as regular meetings where panels were convened so as to facilitate the sharing of experiences, there was an active construction and reconstruction of social lives. Said Low:

The members seem to have an almost unquenchable thirst for social contacts. They visit one another in their homes; they go together to shows and concerts, meet for lunches, for short trips, for joint visits to museums or parks or for plain walks. Some groups have regular schedules for bowling, bam dancing, hiking and swimming. The

families of one North Side and one South side group formed sewing circles.

Consciously or unconsciously, the trend is to break through the dismal isolation and loneliness which have always been the blight of neurotic or post-psychotic existence (Low, 1950: 26-7).

The elision between those aspects of recovery that originated within the realm of Low's expertise as a physician and the forms of social life encouraged through recovery groups calls to mind an argument from Foucault (2002a, p. 59). Here Foucault claims that discursive practices are relational modalities, with networks and connections, whose 'dispersion' across the boundaries of different professional domains gives rise to new 'practices' in care for people with mental health difficulties across a broad spectrum of social discourse and activity. Thus, it may be that moments of crisis in other social and professional contexts have the effect of producing new types of politics, whose subsequent impact affects practice not only in specific fields like health, education and social care but further produces a more "'general politics of truth": that is, the types of discourse it accepts and makes function as true' (Foucault, 1980, p. 131) in other social domains. Shamed by progress in other fields of medicine and the relatively small scale and slow progress of psychoanalytic treatments, psychiatry was casting around for new treatments that provided a sense of decisive scientific action (Valenstein, 1986). It was in this context that North American psychiatrists in the mid-20th century were enthused by European experiments with insulin shock, electroconvulsive therapy and lobotomy. Yet even when these novel procedures were implemented, the psychosocial rehabilitation of the patient was often disappointing. In this context, Low's promotion of a largely patient driven (yet physician supervised) process capable of rehabilitating large numbers of

people, giving them social lives which were recognisably competent and fulfilling, was particularly attractive.

At one – perhaps rather crude - level Low's work represents a more or less explicit attempt to reformulate what, following Foucault, we might call the politics of truth. His focus on challenging defeatist language, where chronicity or overwhelming symptoms were stressed, his insistence on a daylight common sense in the face of the abstractions and obscurantism of psychoanalysis and his championing of the will and its potential to triumph over symptoms represent an important shift in the psychiatric thinking of the day. Some of the techniques of self-scrutiny – spotting and challenging negative, self-defeating thoughts – have found their way into contemporary techniques of cognitive behavioural psychotherapy. Yet despite the decisive break he sought to make with psychoanalysis, there were nevertheless some important parallels. As with psychoanalysis, the person's interior topography could be reconnoitred and mapped to therapeutic advantage. What had hitherto been a private matter of an individual's thoughts, feelings and personal actions was now brought to visibility and became actionable.

As a way of making sense of people and their problems this represents an intriguingly demarcated realm of agency and action for both the practitioner and the client. The nature of inter-war American society is not itself questioned; rather the task is to facilitate the re-entry of the individual into the round of sociability which recovery activities involve. The expertise of Low as the physician, rather than being frequently applied to the situation, is progressively limited as his recoverees become more adroit at managing themselves and one another. The ideas about what to say, think and do, far from being

esoteric, are disarmingly commonsensical within the culture of aspiration and self-help that was popular at the time. This was after all the era of *How to win friends and influence people* (Carnegie, 1936) and *Think and grow rich* (Hill, 1937). But perhaps the foundations had been laid even earlier, with the so called 'new thought' movement of the 19th century, espousing the value of what William James called 'healthy minded attitudes' (Ehrenreich, 2009; Brown and Baker, 2012). This is not to suggest that the contemporary concern with recovery has been simply 'read off' Low's work. As Foucault reminds us, the processes and apparatuses – in other words the *dispositif* - of the phenomena are necessarily heterogeneous across time and place (Foucault, 1980, 194). Rather, the problem is to understand how the puzzling practices of the present can be rendered less puzzling through examination of the past (Garland, 2014, 379).

Self-help and recovery: The twelve step program.

This explicit focus on interior management can be seen also if we consider the early work of another large scale (and perhaps somewhat better known) organisation which has defined, popularised and capitalised upon the idea of recovery. With more than 114,000 groups and over 2.1 million members, Alcoholics Anonymous (AA) is the most accessible and most frequently accessed approach to alcoholism recovery worldwide (Alcoholics Anonymous World Services, 2013). The story of the origin of the Alcoholic Anonymous movement is frequently reprised writing about the organisation. The meeting between William Griffith Wilson and Robert Holbrook Smith (Bill W. and Dr. Bob) in 1935 is often chronicled. As Dr Bob later recalled:

He (Bill W.) gave me information about the subject of alcoholism which was undoubtedly helpful. *Of far more importance was the fact that he was the first living*

human with whom I had ever talked, who knew what he was talking about in regard to alcoholism from actual experience. In other words, he talked my language.

(Alcoholics Anonymous World Services, 2001, p. 180, emphasis in original)

Whilst originally concerned with abstinence from alcohol and the maintenance of sobriety, the scope of AA is much broader (Humphreys and Kaskutas, 1995). It is concerned to effect sufficient change in the member's thinking 'to bring about recovery from alcoholism' (Bill W., 2013) through a spiritual awakening accomplished by following the Twelve Steps (Alcoholics Anonymous World Services, 1984) and sobriety is furthered by volunteering for AA (Alcoholics Anonymous World Services 1983) often in the form of 'sponsorship' of new members. This kind of mutual aid, recollecting the story of Bill W. and Dr. Bob in the early days of their relationship was later codified by Frank Reissman (1965) as 'helper theory', which attempts to explain the therapeutic effect for both people in a "helper" and "helpee" relationship within self-help or mutual-aid support groups. According to Reissman, the process of helping another member, assists the helper in gaining an enhanced sense of self-efficacy making the relationship mutually beneficial (Roberts et al, 1999). This in itself is evidence of how ideas developed and put into practice in self-help movements have enjoyed a kind of symbiosis with social science, such that the latter helps to reify and give focus to the processes originated in these social movements.

The model of Alcoholics Anonymous, based around fellowship, storytelling and adherence to the twelve steps and has been subject to a great deal of research and evaluation.

Summing up the state of the evaluation literature in a 2006 Cochrane Review, Ferri et al (2006) concluded that there was no convincing experimental evidence of effectiveness up

to that point. The effectiveness or otherwise of the programme is however not the key point here. What is more interesting for our purposes is the way that the human condition is conceived and processes of recovery are formulated. Of particular interest here is the role of varieties of dualism. The urge to drink, carefully imbricated with notions of disease, competing with the heartfelt desire to remain sober. The emphasis on communitarian self and mutual help versus the need to submit to a higher power or the authority of the movement as a whole. The emphasis on responsibility in the 'fearless moral inventory' yet the admission of powerlessness over alcohol in the first step of the 12 step programme.

Some critics of this kind of movement have focussed on how it treats much of everyday human conduct as if it were some kind of pathology. For example, popular writer on addiction issues Stanton Peele (e.g. 1999) has claimed that Alcoholics Anonymous perpetuates a model of addiction as a disease which has contributed to the trend of medicalising increasingly large swathes of personal life. Moreover, he says, it treats a whole variety of socially disapproved behaviour with drink and drugs as somehow equivalent and implies the user has no scope for free will. Of course, the concept of medicalization has been widely discussed elsewhere, in relation to a variety of conditions (see *inter alia* Moynihan et al, 2002) and authors have explored how diseases represent and reflect the contours of power, oppression and inequality (Metzl, 2010). With the US vogue for direct to consumer advertising of prescription-only preparations others have more recently added new terms to the armamentarium of the critical commentator on health issues, such as 'pharmaceuticalisation' (Abraham, 2010) to denote the growing tendency to see the human condition not just in medical but in pharmaceutical terms.

Certainly it is not hard to find a focus on the relative permanence and incurability of alcoholism as an illness in AA literature from its inception to the present. For example:

We in AA believe there is no such thing as a cure for alcoholism. We can never return to normal drinking and our ability to stay away from alcohol depends on maintaining our physical, mental and spiritual health (Alcoholics Anonymous World Services, 1980: 4).

With this example, at a first reading it is easy to see discourse like this in Foucauldian terms, as the exercise of a kind of 'bio-power', which through its 'enframing' as a relatively incurable illness, serves to define the terms of reference under which sufferers should make themselves governable and subject to the 'conduct of conducts' (Foucault, 1983). In relation to this, Foucault is referring to the paradox of liberalism: the sovereignty of the free individual versus the requirement for regulation and control. At stake also is the dualism or tension between those parts of the self which are incorrigible, such as the 'illness' and those which are sentient, intentional and capable of following a programme of recovery. The example of AA is useful then because it shows how ideas about recovery can assimilate and inform different technologies and practices across a variety of fields. From the secularism of Low's work to the spiritually-informed world view of AA, there are commonalities in the way the person in health and illness was seen - what Foucault termed 'a space of dispersion . . . an open field of relationships' (1978, 11), which engendered similar ideas and practices across different domains. In his early works Foucault wrote of the 'episteme' of a period; 'the discursive practices which give rise to epistemological figures, sciences and possibly formalised systems' (Foucault, 1972, 191). These practical fields in which discourses of the self were deployed (Foucault, 1978, 15)

encompassing - and in an important sense, constituting - mental ill health and alcoholism facilitated and consolidated these ways of self-understanding.

The history of recovery in the present

For the present argument, what is most interesting is the residue of these enframings in contemporary accounts of recovery in broader mental health contexts. The underlying logic of recovery is shaped by this kind of ineluctable core of pathology. The illness is seen as present, real and imposing tangible parameters. Recovery involves the responsible, resourceful (and often expert advised) attempt to on the part of the individual to work around the illness. As Slade (2010) puts it:

“recovery”: the development of new meaning and purpose in one’s life, irrespective of the presence or absence of symptoms of mental illness.

Foucault notes the three important transformations in the exercise of the care of the self as its practice evolved: the way in which it became a principle of constant care throughout life; its acquiring a self-corrective, self-protective and therapeutic function; and its increasing reliance upon supportive relationships in general rather than upon one special friendship.

‘Recovery refers to the lived or real life experience of persons as they accept or overcome the challenge of their disability. We might say that rehabilitation refers to the ‘world pole’ and that recovery refers to the ‘self pole’ of the same phenomenon’ (Deegan, 1988: 11).

‘The three cornerstones of recovery – hope, willingness and responsible action’

(Deegan, 1988: 14).

Limitation is privileged:

‘Our recovery is marked by an ever deepening awareness of our own limitations. But now, rather than being an occasion for despair, we find that our personal limitations are the ground from which spring our own unique possibilities’ (Deegan, 1988: 14-15)

Nearer the present, recovery processes are also said by their enthusiasts to be marked by changes in the interior and intersubjective world of those who are recovering:

The recovery processes that have the most proximal relevance to clinical research and practice are: connectedness; hope and optimism about the future; identity; meaning in life; and empowerment (giving the acronym CHIME) (Leamy et al, 2011: 445).

The attractiveness of recovery as a way of making sense of mental health practice, as a guide for action and as a means of understanding what is happening to people under new regimes of mental health care can perhaps be set in context by considering the changes that have taken place in the delivery and science of mental health in the previous half century. The biggest change in mental health care, the de-institutionalisation and closure of the large mental hospitals, once heralded as a humane and technical revolution, has had mixed results (Leff, 2001). Concerns remain about how much this change has

contributed to improved mental health of society, with reports of increased social isolation and social exclusion (Centre for Social Justice, 2011), and higher rates of imprisonment among those experiencing mental health problems (Edgar and Rickford, 2009; HM Inspectorate of Prisons, 2007). Together these challenges and responses have undermined service user trust in professional care and contributed to a growing public scepticism about the effectiveness of mental health services, together with a decline in the perceived capacity of therapists to identify and manage risks or create resilience, and tensions between law and mental health care (Bentall 2009). A strong line of response from the biomedical research community has been a renewed emphasis on biomedical and neuroscience innovation, but with little confidence of success as noted by Medical Research Council (2010, section 1.4.1). Therefore there is an appetite on the part of policymakers, practitioners, service users and carers for approaches that offer novelty and a promising response to problems that might otherwise seem overwhelming and intractable.

In working around and within existing notions of illness and symptomatology and interpellating itself with contemporary self-culture, the idea of recovery is neither static nor preordained, but has rather transformed as a 'subject that constitutes itself within history and is constantly established and re-established by history' (Foucault, 2002b, p. 4) and events within society. Such is the enthusiasm for recovery-oriented services in present day UK mental health that it has the status, in Foucauldian terms, as a new 'enunciative homogeneity' (Foucault, 2002a, p. 162) or a common lexicon of recovery signifiers, where mental ill health symptoms which may themselves be intractable, can be subject to individual and group amelioration.

A function of disciplinary power (Foucault, 1983) is to guide the possibility of recovery conduct by putting in order the possible outcome. On the assumption of 'sameness', all potential recoverees are regarded equal and thus required to follow and implement the guidelines of a universal therapeutic regime. The 'art of government' (Foucault, 1979) relies upon the 'universal service user' to inscribe within him or herself a vision of ethics, as a kind of relationship with the self ('rapport a soi'), where the individual 'constitute[s] himself[/herself] as a moral subject of his[/her] own actions' (Foucault, 1991, p. 352). Hence Deegan's 'responsible action' and the cultivation (in this homogenous regimen) of 'unique possibilities'.

We are not asserting that the architects of contemporary recovery policy and practice have deliberately and purposefully populated the movement from the insights of Low, or Bill and Bob. Instead what we are proposing is that the process reflects what Nikolas Rose and before him Michel Foucault would see as the 'capillary' nature of power and influence. The practices of recovery are locally implemented and are true in a much more particular sense than if they resulted from the imposition of some wide ranging ulterior fiat. They are thought up and put into practice without explicit reference to a thoroughgoing intellectual history - perhaps why the quote from Anthony (1993) is so widely used. As Rose's collaborator Peter Miller describes in his work on what he calls the 'calculating self', the continual process of reorganising and reconfiguring consciousness and the self which is peculiar to the modern age goes hand in hand with the shaping of subjectivity or forms of personhood (Miller and Rose, 2008). This provides new possibilities for acting on oneself and on the actions of others. Certainly, this process does

not always work seamlessly. The 'technologies' (in Foucault's terms) with which personhood can be shaped are always to a greater or lesser degree ineffective, either through outright resistance or through their failure to gain sufficient purchase on the public imagination. The instruments for the governance of conduct, and the rationalities that articulate the aims and objectives of governing, may frequently encounter limits regarding what can be done (Mennicken, 2008). The notion that one can culture and cultivate the self through therapy, healing and self-help seems today to travel effortlessly across a vast range of territories (Illouz, 2008). But other devices, for instance thinking through the lens of structural inequalities, seem to travel with increasing difficulty. This suggests that we still have much to find out about how the different dimensions of the recovering self travel, and how this peculiarly modern form of personhood is fashioned and refashioned in historically specific assemblages. Thus, we would want to point to a degree of consilience between the variety of practices which seek to manage mental health, formulate health risks, operationalize and shape desirable conduct, and specify a desired mindset on the part of citizens, because as Rose puts it, these practices 'spread out over a variety of surfaces'.

Practices of recovery become as much about gaining purchase on the management of identities as they do on the nature and structure of services. The new recovery-based identities involve constitutive regulatory norms that are embodied and performed by service users and practitioners. As Foucault (1977, p. 194) might say that which 'does not measure up to the rule, that departs from it', is punishable and thus serves to classify, govern and divide those undergoing recovery from their dubious and dangerous antithesis

– those who are ‘hard to engage’, not ‘psychologically minded’ or who are ‘resistant to treatment’.

Conclusion: interior recoveries, exterior transformations

Our argument is not so much that gaining a socio-political purchase on the notion of recovery is better than the language of interiority that has predominated so far. It is hard to weigh up the merits of different kinds of approaches in any simple sense, and there are no comparative outcome studies addressing this question to our knowledge. Rather, the interesting question is how this particular kind of architecture has been brought to visibility as a result of social, intellectual and rehabilitative practice, what its antecedents are and how this might help us understand its form and function in the present. The acceptance and reinforcement of the limits imposed by an underlying illness whose ontology often goes unchallenged, the focus on interior life and the schism between the illness which remains in medical hands and the psychosocial recovery which is in the hands of the client have been continuous features of these approaches for what is now approaching a century. The persistence of a sense of deficit in the client has been equally robust across time and in differing national contexts. There is at the same time a reformulation of the social away from collective action and politics and toward interpersonal processes such as support and education, often closely aligned with medicalised concepts of distress and illness. Awareness of the histories of these tendencies in the concept and practice of recovery will make it easier for those in distress, their carers and healthcare providers, to decide whether this model is genuinely helpful to them and which aspects if any they wish to retain. A historical approach of this kind

implies that current notions of recovery are but one of a variety of options, and that alternatives which focus less on the interior realm and more on the circumstances in which recovery might emerge *sui generis* might have more to offer. In this vein, Dillon (2011) outlines a political and collective approach to recovery, arguing that 'improving all of our personal experiences means that we must collectively address oppressive political structures. This for me is why the personal is political' (2011, 157).

Taking this argument, in contrast to a version of recovery focussed on the psychological realm, the economic impact of being identified as a psychiatric patient could be foregrounded instead, together with the social and political consequences of this identification. For as Harper and Speed (2012) say, when the economic disadvantage and pejorative typification of people with mental health problems are considered together then the extent of the social injustice can be fully appreciated, and the most effective means of addressing it can be implemented. Whilst personal experiences are important, it is also valuable to attend to the social structural conditions which facilitate "coming through" adversity or "moving forward" (Ochocka et al., 2005).

Relationships between service users and health professionals are not always harmonious, and are sometimes problematic. A perspective that transcends the legacy of inner psychic life, acknowledging these conflicts, and which is capable of addressing power disparities in relation to professionals and institutions will be transformative and emancipatory in a more thoroughgoing way. Moreover, it may well point to areas where efforts for transformation and liberation may best be directed.

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